

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF HEALTH
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

43976

State File No. _____

Registration District No. 792

Primary Registration District No. 4473

Registrar's No. _____

1. PLACE OF DEATH

- (a) County Saline
(b) City or town Arrow Rock
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution _____ (Specify whether

In this community 70 years years, months or days) _____

3. (a) PRINT FULL NAME Pardee C. Bingham

3. (b) If veteran, name war V 3. (c) Social Security No. ✓

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Jacob Bingham 6. (c) Age of husband or wife if

alive _____ years
7. Birth date of deceased Dec 4 1864
(Month) (Day) (Year)

8. AGE: Years 76 Months 10 Days 16 If less than one day
hr. _____ min. _____

9. Birthplace Muskegon Co. Mich. (City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business _____

- MOTHER FATHER { 12. Name James Crutcher

13. Birthplace Mich. (City, town, or county) (State or foreign country)

14. Maiden name Margaret Cook (City, town, or county) (State or foreign country)

15. Birthplace Mich. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Harold Pardee

- (b) Address Arrow Rock, Mo.

17. (a) Burial (b) Date thereof Dec 22 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation Arrow Rock, Mo.

18. (a) Signature of funeral director Marshall Lewis

- (b) Address Marshall 770

19. (a) 1-2-1941 (b) L. Lawless
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Saline

- (c) City or town Arrow Rock, Mo.
(If outside city or town limits, write "RURAL")

- (d) Street No. _____ (If rural, give location)

- (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 20th
year 1941 hour 9 minutes 30 A.M.

21. I hereby certify that I attended the deceased from Nov. 1
1940 to Dec. 20 1940
that I last saw her alive on Dec. 19 1940
and that death occurred on the date and hour stated above.

- Immediate cause of death _____ Duration _____

Angina Pectoris

- Due to Senility

- Due to Arteriosclerosis

- Other conditions Arthritis (Include pregnancy within 3 months of death) 94 1/2

- Major findings: Of operations none

- Of autopsy none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) no

- (b) Date of occurrence _____

- (c) Where did injury occur? _____ (City or town) (County) (State)

- (d) Did injury occur in or about home, on farm, in industrial place, in public place? no

- (Specify type of place)

- While at work? _____ (e) Means of injury _____

23. Signature M.S. McQuinn (M. D. or other) 1

- Address Boonville Mo. Date signed 12/20/40

RECEIVED
District Health Officer No. 8,
Date Filed 1-14-41
of the Number 1-14-41

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed

Joe H. Currie

Licensed Embalmer No. 1171

P. O. Address Marshall M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.